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Outpatient Ultrasound / Echocardiogram Referral Form

Referring Veterinarian: _____	Client Name: _____
Clinic / Hospital: _____	Client Contact No: _____
Clinic Email: _____	

Patient Information

Name: _____ Sex: M F Sterilised: Y N

Species: _____ Breed: _____ Age: _____ Weight: _____

Study (Please check where applicable)

<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Ocular
	<input type="checkbox"/> Neck	<input type="checkbox"/> Thoracic
	<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/> Others: _____
<input type="checkbox"/> Echocardiogram		

Presenting problem / Tentative diagnosis	Clinical question / Region of interest
_____	_____
_____	_____
_____	_____

Case history / Physical examination findings summary	Current treatment(s) (including medications and dosages)
_____	_____
_____	_____
_____	_____

	Y*	N	
Any concerns regarding sedation? (ultrasound only)	<input type="checkbox"/>	<input type="checkbox"/>	*If yes, please specify: _____
Has prior imaging been done?	<input type="checkbox"/>	<input type="checkbox"/>	*If yes, please attach results
Has patient history been sent to hx@lvs.com.sg?	<input type="checkbox"/>	<input type="checkbox"/>	

Reports will be sent via email to the referring veterinarian within 48 hours from completion of the study.

 Signature / Date